

Sailors and Marines Reducing Mishaps

BRAVGO Zulu



Send BZs to: SAFE-Mech@navy.mil



AM3 Michael Monroe
HM-15

Petty Officer Monroe noticed a broken section of the cowl screen on the tail gearbox while preflighting the tail-rotor driveshaft on Hurricane 07. Although the daily and turnaround inspection had revealed no discrepancies in that area, he notified his crew chief. Upon closer inspection, the crew chief found the screen had separated and peeled back from the airframe.

Petty Officer Monroe's actions prevented a possible in-flight cowl failure that could have resulted in severe damage to the tail rotor and loss of the aircraft and crew.



AM2(AW) Kenneth Hassler
HS-11

During a daily and turnaround inspection, Petty Officer Hassler discovered a half-inch-by-7-inch delaminated section on the blue tail-rotor blade. He immediately downed the aircraft until critical repairs could be completed.

Petty Officer Hassler's action prevented the tail rotor from departing the aircraft and resulting in loss of aircrew and aircraft.

Sgt. Timothy O'Connor
HMM-165

While conducting humanitarian missions in Indonesia during Operation Unified Assistance, Sgt. O'Connor (a CH-53E crew chief) discovered a worn pitch-control rod and bearing. He checked the integrity of the rod on a preflight inspection of the rotor-head assembly and noticed an unusual amount of play between the inner bearing and outer race. The Teflon that surrounds the bearing had worn down, allowing the bearing and the race to make metal-to-metal contact.

If Sgt. Connor had not discovered this condition, it would have caused the bearing to break loose and would have allowed the rod end to strike the sleeve and spindle, causing a total loss of control of the main rotor blade and supporting assembly.





AM1 Flennoy Bellinger
HS-5

While preparing to launch aircraft 615 as part of a two-helicopter launch, Petty Officer Bellinger glanced at aircraft 617 departing off the starboard beam of the ship. He noticed that the tail driveshaft cowling didn't look right. He immediately went to the tower and requested radio contact with 617. He told the pilots to have the aircrew visually check the cowling to make sure it was secured.

The aircrew checked and confirmed that it wasn't secure. Petty Officer Bellinger then safely and expeditiously shut down aircraft 615 and directed that it be moved into the hangar to make a ready deck to recover 617.

Petty Officer Bellinger quickly made the necessary repairs and got the aircraft airborne in just 15 minutes.



Cpl Adam Gomez
HMLA-169

During a daily and turn-around inspection while deployed to Iraq, Cpl. Gomez found severe scoring of the No. 2 tail-rotor driveshaft in multiple locations of an AH-1W. A broken Dzus fastener receptacle had fallen off the driveshaft access panel and lodged against the driveshaft. The driveshaft was removed for further inspection, and a crack was found from excessive scoring.

Cpl Gomez's thorough inspection potentially saved the aircrew and aircraft from a catastrophic tail-rotor failure.



AMS3 Robert Tiller
HS-5

Petty Officer Robert Tiller noticed something a little peculiar while working on a turn-around inspection of a squadron SH-60 helicopter. Upon closer inspection, he discovered and immediately reported a small tear on one of the plastic-coated, power available spindle (PAS) cables on an SH-60 helicopter. Had it not been for his keen attention to detail and quick response, the helo and its crew could have been in grave danger.

AMAN Ricardo Amezcua
CPRW-5

While helping to move an aircraft at night and in the rain, AMAN Amezcua heard a scraping noise coming from the port main mount on a P-3C. He halted the move and called for an immediate inspection of the main mount. That inspection revealed the wheel assembly was canted slightly and was broken.

Had the move continued, the wheel could have departed the aircraft, causing major damage to the aircraft and possible injury to ground personnel.





AMEAR Bryan Cunningham
VAQ-135

While on a weekend security watch and during a walk-through of the hangar, AMEAR Cunningham noticed the whistling sound of a leaking liquid oxygen tank in aircraft 500. Upon further investigation, he found two of the aircraft's three liquid oxygen tanks nearly encased in ice.

After consulting with a senior CDI/QAR for advice, he removed the tanks from the aircraft and drained them, a task made arduous by the dangerous and volatile nature of liquid oxygen.

Had this situation gone unnoticed, the liquid oxygen tank could have exploded.



Mark Oakes
NAVAIR Pax River

On an MH-60R's 30-hour inspection, Mark Oakes discovered evidence of a crack that warranted further investigation.

The area was stripped, and the NDI lab inspected it, confirming a 1.8-inch crack at station 327 and just forward of the main beam, preventing the potential loss of aircraft and crew.



AD1 Mike Williamson
VAQ-142

While troubleshooting compressor stalls on the port engine of aircraft 522, Petty Officer Williamson went the extra mile to determine the cause. Despite a thorough external inspection and ground maintenance turn that wasn't able to duplicate the problem, he decided to do a bore-scope inspection of the engine and found foreign object damage in the sixth stage.



AM3 Craig Powers
VF-213

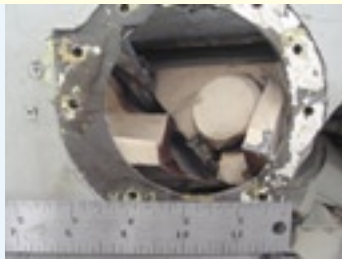
While doing flight-deck familiarization training from vulture's row onboard USS *Theodore Roosevelt* (CVN-71), Petty Officer Powers noticed a problem while pointing out hazardous areas in and around the landing area. He saw that the cable-support spring for the No. 3 arresting gear had broken after an E-2C Hawkeye did a touch and go landing.

Realizing that the flight-deck crew had not noticed the problem, Petty Officer Powers sprung into action and alerted a member of the crash crew. Flight-deck and primary control were notified in time to wave-off the air wing commander flying Blacklion 205, averting a possible mishap.

AM3 James Bales
VAW-115

While doing a turn-around inspection on aircraft 603, Petty Officer Bales noticed a torque stripe was broken on one of the starboard wing-fold connecting points. He meticulously inspected the wing's hinge and discovered catastrophic failure on the upper section.

Petty Officer Bales promptly reported his finding to the flight-deck coordinator and also notified maintenance control, averting a potentially catastrophic condition. The repair required the removal and replacement of the entire starboard wing.



AMAN Amy Harmon
VFA-204

On a daily inspection of River 403, Airman Harmon noticed a very faint defect in the trunnion on the starboard main landing gear. During a closer inspection of the trunnion, she determined the problem likely was a crack. She immediately notified maintenance control that the aircraft was down.

After removing the item for NDI inspection, maintainers found a nine-inch crack in the trunnion. Because of the obscure location of the defect, Airman Harmon found this defect only because of her thorough inspection and extreme attention to detail. This find prevented the catastrophic failure of the landing gear.



ADCS Gene Casterlin
VF-31

Flight-deck crews reported a grinding noise coming from Felix 100 after it landed on USS *Theodore Roosevelt* (CVN-71). The aircrew hadn't noticed any engine abnormalities throughout the flight, but they did feel a slight aircraft vibration just before landing. The aircraft was downed for further inspection.

External inspection of the aircraft and motor casings, inlet and exhaust sections revealed no discrepancies. Senior Chief Casterlin, the QAS, directed a thorough borescope inspection of both engines' combustion chambers and turbine sections. The inspection revealed that 83 percent of the port engine's high-pressure-turbine blades were cracked and beginning to deteriorate. Senior Chief Casterlin's persistence found the root cause of a potentially deadly discrepancy.



AME2 (AW) Michael Floate
VFA-151

Petty Officer Floate was supervising the installation of FA-18 ejection system components in aircraft 301 when he discovered the aft-support bracket for the canopy rocket motor had been manufactured incorrectly.

Had this bracket been installed it may have resulted in serious injury to aircrew, or even loss of life, if a pilot had to eject. Petty Officer Floate's initiative, attention to detail, and in-depth knowledge of the F/A-18 systems prevented this situation from happening.